Exhibit A
Order No. G 04-79
Market Conduct Examination

MARKET CONDUCT EXAMINATION

REGENCE BLUE SHIELD
REGENCECARE
ASURIS NORTHWEST HEALTH

1800 NINTH AVENUE
SEATTLE, WASHINGTON 98101

July 1, 2001 – December 31, 2002

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The Honorable Mike Kreidler
Washington State Insurance Commissioner
P.O. Box 40255
Olympia, Washington 98504

Dear Commissioner Kreidler:

Pursuant to your instructions and in compliance with the statutory requirements of RCW 48.44.145 and RCW 48.46.120 and procedures promulgated by the National Association of Insurance Commissioners and the Office of the Insurance Commissioner (OIC), an examination of the market conduct affairs has been performed of:

Regence Blue Shield, NAIC #53902
RegenceCare, NAIC #95648
Asuris Northwest Health, NAIC# 47350
1800 Ninth Avenue
Seattle, Washington 98101

In this report, Regence Blue Shield is referred to as RBS. RegenceCare is referred to as RC. Asuris Northwest Health is referred to as ANH. Collectively these entities are referred to as the Companies.

This report of examination is respectfully submitted.

CHIEF EXAMINER'S REPORT CERTIFICATION and ACKNOWLEDGEMENTS

This examination was conducted in accordance with Office of Insurance Commissioner and National Association of Insurance Commissioners market conduct examination procedures. Nancy L. Barnes, AIE, ACS; George J. Lazur, CIE, CPCU; and Charlotte F. Wright of the Washington State Office of Insurance Commissioner performed this examination and participated in the preparation of this report.

The examiners wish to express appreciation for the courtesy and cooperation extended by the personnel of Regence BlueShield, RegenceCare, and Asuris Northwest Health during the course of this market conduct examination.

I certify that the following is the report of the examination, that I have reviewed this report in conjunction with pertinent examination work papers, that this report meets the provisions for such reports prescribed by the Office of Insurance Commissioner and that this report is true and correct to the best of my knowledge and belief.

Leslie A. Krier, AIE, FLMI
Chief Market Conduct Examiner
Office of the Insurance Commissioner
State of Washington

FOREWORD

This examination was completed by applying tests to each examination standard. Each test applied during the examination is stated in this report and the results are reported. Exceptions are noted as part of the comments for the applied test. Throughout the report, where cited, RCW refers to the Revised Code of Washington, and WAC refers to Washington Administrative Code.

Scope

Time Frame

The examination covered the Companies' operations from July 1, 2001 through December 31, 2002. This was the first market conduct examination of RegenceCare and Asuris Northwest Health. There was a prior examination in 1997 of King County Medical Blue Shield, the predecessor for Regence BlueShield. This examination was performed both in the Seattle OIC office and on-site at the Companies' offices in Seattle, Washington.

Matters Examined

The examination included a review of the following areas:

Company Operations & Management	Advertising
Claims	Underwriting
Member Contracts and Handbooks	Provider Contracts

Sampling Standards

Methodology

In general, the sample for each test utilized in this examination falls within the following guidelines:

92 %	Confidence Level
+/- 5 %	Mathematical Tolerance.

Regulatory Standards

Market conduct samples are tested for compliance with standards established by the OIC. The tests applied to sampled data will result in an error ratio, which determines whether or not a standard is met. If the error ratio found in the sample is, generally, less than 5%, the standard will be considered as met. The standards in the area of agent licensing and appointment, and

policy and form filings will not be met if any violation is identified. This will also apply when all records are examined, in lieu of a sample.

For those standards, which look for the existence of written procedures, or a process to be in place, the standard will be met based on the examiner's analysis of those procedures or processes. The analysis will include a determination of whether or not the company follows established procedures.

Standards will be reported as Passed (without Comment), Passed with Comment or Failed. The definition of each category follows:

Passed	There were no findings for the standard.
Passed with Comment	Errors in the records reviewed fell within the tolerance level for that standard.
Failed	Errors in the records reviewed fell outside of the tolerance level established for the standard.

COMPANY OPERATIONS AND MANAGEMENT

Company History

Regence BlueShield was originally organized as King County Medical Service Corporation (KCMSC) in 1933, and was issued a Certificate of Registration by the Office of Insurance Commissioner on September 5, 1947. On November 23, 1970, KCMSC changed its name to King County Medical Blue Shield (KCMBS). Between 1983 and 1995 KCMBS merged with seven (7) other medical bureaus:

- Lewis County Medical Services
- Pierce County Medical Bureau
- Cowlitz Medical Service
- Thurston County Medical Bureau
- Snohomish County Physicians Corporation
- Grays Harbor Medical Bureau
- Clallam County Physicians Service, Inc.

The name was changed again on April 1, 1997 to Regence Washington Health and on April 16, 1998 to Regence BlueShield (RBS). On January 1, 2000, RBS merged with Northwest Washington Medical Bureau. The surviving entity was RBS.

RegenceCare was originally incorporated as HMO Washington, Inc. on March 17, 1986 as a wholly owned subsidiary of King County Medical Blue Shield, and was issued a Certificate of Registration by the OIC on May 1, 1986. In March 1998, HMO Washington changed its name to RegenceCare.

Asuris Northwest Health was originally incorporated as Walla Walla Valley Medical Service Corporation in 1933, and was issued a Certificate of Registration by the OIC on September 5, 1947. It was acquired by RBS in November 1994. The name was changed to Regence Northwest Health in 1997 and to Asuris Northwest Health in September 2002.

Asuris Northwest Health (ANH), a Health Care Service Contractor, and RegenceCare (RC), a Health Maintenance Organization, are wholly owned subsidiaries of Regence BlueShield.

Company Management & Operations

A Board of Directors governs Regence BlueShield, the sole shareholder of RegenceCare and Asuris Northwest Health. Directors are nominated by the Organizational and Governance Committee of the RBS Board. Directors are then elected at the first meeting of the year by the full Board, subject to final approval by The Regence Group (TRG). TRG is the sole shareholder of RBS. The directors serve staggered 3-year terms with a limit of three consecutive terms. The RBS Board meets on a quarterly basis to discuss issues and to conduct

oversight of operations of RBS. Minutes from all meetings are maintained in the corporate and legal departments in the Seattle, Washington offices of RBS. The members of the current Board of Directors for Regence BlueShield are:

Board Member Position/Representation	Company / Community Affiliation	Elected By	Original Appointment Date	Term Expires
Mark C. Adams	Thoracic Vascular Center	RBS Board	2002	2005
Jerome N. Alhadeff	ABC Pacific Corp.	RBS Board	1997	2005
Mavis R. Berke	Retired (Swedish Medical Center)	RBS Board	1997	2005
James M. Foss, M.D.	Sole Practitioner	RBS Board	1997	2003
Clifton T. Furukawa, M.D. (resigned 04-02)	Children's Hospital and Medical Center	RBS Board	1997	2002
Mack L. Hogans	Weyerhauser	RBS Board	2000	2003
Michael A. Leff, M.D	Overlake Plastic Surgeons	RBS Board	1997	2004
William G. Marsh, M.D.	The Summit View Clinic	RBS Board	1997	2003
Mary O. McWilliams	President / CEO, RBS	RBS Board	2000	Tenure as President
Erling O. Mork	Retired (City of Tacoma)	RBS Board	1997	2004
H. Stewart Parker	Targeted Genetics Corp.	RBS Board	1997	2005
Norman B. Rice (resigned 09-03)	Federal Home Loan Bank of Seattle	RBS Board	2000	2003
Jack G. Strother	Graham & Dunn	RBS Board	1997	2003
Terry W. Torgenrud, M.D.	University Pediatrics	RBS Board	1997	2005
James F. Wells	IGM Communications	RBS Board	2001	2004
Robert R. Witham, M.D.	Sole Practitioner	RBS Board	1997	2004
Richard L. Woolworth, ex officio (resigned 12-03)	Former Chairman, CEO, The Regence Group	RBS Board	2002	2003

The RegenceCare Board of Directors is elected by RBS, as the sole shareholder of RegenceCare, at the RC Annual Shareholder's Meeting. The directors serve staggered 3-year terms. The Board holds a second meeting in the fall to discuss issues and to conduct oversight of operations of RC. The members of the current Board of Directors for RegenceCare are:

Board Member Position/Representation	Company / Community Affiliation	Elected By	Original Appointment Date	Term Expires
Rennie Coit, M.D.	RBS	Shareholder (RBS)	2001	2002
Leslie Foy (resigned 01-03)	Guidant Corporation	Shareholder (RBS)	2001	2004
Karen Jenkins	Valley General Hospital	Shareholder (RBS)	2003	2004
Mary O. McWilliams	President / CEO, RBS	Shareholder (RBS)	1998	2004
Jeffrey A. Robertson, M.D.	RBS	Shareholder (RBS)	1999	2004
Brian Westerlund (resigned 08-02)	Metro Cellular	Shareholder (RBS)	1997	2002

The Asuris Northwest Health Board of Directors is elected by RBS, as the sole shareholder of Asuris Northwest Health, at the ANH Annual Shareholder's Meeting. The directors serve staggered 5-year terms. The members of the current Board of Directors for Asuris Northwest Health are:

Board Member Position/Representation	Company / Community Affiliation	Elected By	Original Appointment Date	Term Expires
Mary O. McWilliams	President / CEO, RBS	Shareholder (RBS)	1999	2004
John H. Pierce (resigned 2002)	Sr. VP, RBS	Shareholder (RBS)	1999	2002
Jo Anne C. Long	Secretary, ANH; VP / General Counsel, RBS	Shareholder (RBS)	2001	2003
Cary P. Badger	VP, RBS	Shareholder (RBS)	2002	2004

Territory of Operations

During the examination period, RBS operated in 23 counties in Washington State. The Company operates in these counties: Clallam, Columbia, Cowlitz, Grays Harbor, Island, Jefferson, King, Kitsap, Klickitat, Lewis, Mason, Pacific, Pierce, Skagit, San Juan, Skagit,

Skamania, Snohomish, Thurston, Wahkiakum, Walla Walla, Whatcom and Yakima. Providers are also available to plan members in contiguous counties: Benton, Garfield, Grant and Kittitas.

During the examination period, RC operated in 10 counties in Washington State: Clallam, Grays Harbor, Jefferson, King, Kitsap, Mason, Pacific, Pierce, Skagit and Snohomish.

During the examination period, ANH operated in all of the counties in Washington State.

The examiners did not find any evidence that the Companies are operating outside of the stated territory of operation.

Findings

Company Operations Standard #2 is not applicable to this examination. The examiners did not review the minutes of the Board of Director meetings.

The following Company Operations & Management Standards passed without comment:

	Company Operations & Management Standard	Reference
1	The Company is required to be registered with the Office of Insurance Commissioner prior to acting as a health care service contractor or health maintenance organization in the State of Washington.	HCSC Reference
		RCW 48.44.015(1)
		HMO Reference
		RCW 48.46.027(1)
3	At least one-third of the HMO's board of directors is made up of consumers who are representative of the enrolled population.	HCSC Reference
		None
		HMO Reference
		RCW 48.46.070(1)

GENERAL EXAMINATION FINDINGS

The Companies' records and operations were reviewed to determine if the Companies do business in accordance with the requirements of this state. The examiners found that in most cases, the Companies' records are in order and the Companies follow laws and regulations pertaining to general company operations.

The following General Examination Standards passed without comment:

#	General Examination Standards	Reference
1	The Company does business in good faith, and practices honesty and equity in all transactions.	HCSC/HMO Reference
		RCW 48.01.030

#	General Examination Standards	Reference
3	**The Company may not discourage members from contacting the OIC and may not discriminate against those members that do contact the OIC.**	**HCSC/HMO Reference** **WAC 284-30-572(2)**

The following General Examination Standard passed with comment:

#	General Examination Standard	Reference
2	**The Company facilitates the examination process by providing its accounts, records, documents and files to the examiners upon request.**	**HCSC Reference** **RCW 48.44.145(2)** **HMO Reference** **RCW 48.46.120(2)**

General Examination Standard #2:

The Company was not able to readily produce all of the documents requested by the examiners.

- There were two (2) files missing from the Regence BlueShield Individual Underwriting New Issue sample of 41 files. See Appendix 1.

ADVERTISING

The Companies' advertising materials are prepared in multiple departments that communicate with the public, brokers, member groups and individual members. Oversight of the production of advertising materials created by all of the departments, including the Companies' websites, is done by the Corporate Communications department.

The Companies were asked to provide a listing of advertising materials in use during the examination period. The examiners were provided with a list of 610 items which included the website information. In addition to the listing, the Companies provided a packet of materials that included 9 hard copy items and a CD-Rom containing an additional 10 items, which were not on the list of 610 items. The total number of advertising materials was 629 items. During the review, the examiners determined that one of the hard copy items pertained to programs outside the scope of the examination and it was eliminated from the population.

The examiners reviewed 68 of the Companies' advertising pieces: 50 pieces randomly selected from the list of 610 items, and the additional 18 items that were not included in the initial advertising file.

Of the 68 items, 59 were used exclusively for the HCSC's, five (5) were used exclusively for the HMO, and four (4), including the website, were used to advertise both HCSC's and the HMO.

Findings

The following Advertising Standards passed without comment:

#	Advertising Standard	Reference
1	The Company cannot advertise a plan to prevent illness or promote health unless a) the clinical preventive benefits are the same as the basic health plan; b) it monitors and reports annually to enrollees on standards of health care and satisfaction of enrollees; c) it makes available its plan to identify and manage the most prevalent diseases within its enrolled population on request.	HCSC/HMO Reference RCW 48.43.510(5), WAC 284-43-820(5)
3	The Company cannot make misleading comparisons with other companies to induce the consumer to change from another HCSC or HMO.	HCSC Reference RCW 48.44.140 HMO Reference RCW 48.46.410
6	The Company must comply with all health plan disclosures as required by regulation.	HCSC/HMO Reference WAC 284-43-820(1) through WAC 284-43-820(3)
8	A Health Care Service Contractor cannot guarantee future dividends or future refunds except in group contracts with an experience refund provision.	HCSC Reference RCW 48.44.130 HMO Reference None
9	No Health Maintenance Organization may use the words "insurance", "casualty", "surety", or "mutual" to describe itself in its advertising materials.	HCSC Reference None HMO Reference RCW 48.46.110(1)

The following Advertising Standards passed with comment:

#	Advertising Standard	Reference
2	No advertising may contain any false, deceptive or misleading information.	HCSC Reference RCW 48.44.110 HMO Reference RCW 48.46.400
4	The Company complies with the Washington Disability Insurance Advertising Regulations.	HCSC/HMO Reference WAC 284-50-010 through WAC 284-50-230

#	Advertising Standard	Reference
7	The Company cannot misrepresent the terms, benefits, or advantages of the contract.	HCSC Reference
		RCW 48.44.120, WAC 284-50-050
		HMO Reference
		RCW 48.46.060(2) and (3), WAC 284-50-050

Advertising Standards #2, #4, #7:
Three (3) benefit summaries (Custom Benefit Summary The Association Plan 03/01, Custom Benefit Summary The Association Plan 04/02, and Basic Summary of Benefits) erroneously outline the benefits for maternity and chiropractic coverage. The summaries state that for groups of five (5) or less under the association group plan, maternity benefits are reduced by 50 percent. In addition, the chiropractic benefit is excluded. These actions violate RCW 48.44.110, RCW 48.46.400, WAC 284-50-060(1), RCW 48.44.120, RCW 48.46.060(2), and WAC 284-50-050.

Subsequent Event: The Companies and the OIC reached an agreement that the Companies would voluntarily begin processing all maternity claims at 100% network/70% out of network coincident with The Association Plan's March 1, 2003 renewal.

The following Advertising Standard failed:

#	Advertising Standard	Reference
5	The Company maintains a complete advertising file.	HCSC/HMO Reference
		WAC 284-50-200

Advertising Standard #5:
The 8 paper and 10 CD-Rom items provided by the Company were not on the list of 610 advertising items represented as the Company's advertising file. See Appendix 2.

Subsequent Event: The Companies revised the advertising procedures on January 19, 2004, retroactive to January 1, 2003, to include processes for document retention and storage.

CLAIMS

Claim Processing Manual

The Companies provided the examiners access to the claims processing manual. This manual is maintained online on the Companies' computer system. The purpose of the manual is to provide a consistent overview of the Companies' Affiliated Computer Systems (ACS) in a single source document. The examiners were also provided with the Boeing Selections claims

processing manual. This manual is maintained in paper format. The online claims processing manual and the Boeing Selections claims processing manual were both found to be accurate, and both thoroughly describe the Companies' claims processing policies and procedures.

Claims Processing

The Companies receive claims both electronically and in paper format. Claims are adjudicated in The Regence Group's offices in Salt Lake City, Utah and in the Companies' offices in Seattle. Paper claims are received in Salt Lake City and in Seattle. Providers are instructed to send their claims to Salt Lake City. Claims that are submitted by a member are sent to Seattle. Electronic submissions are downloaded to the Companies' Claims Processing System (CPS) in Salt Lake City.

Incoming paper claims are batched and scanned the same day that they are received. Hard copies of claims are maintained onsite for two (2) weeks. After that time, they are shredded. All claims are maintained either in imaged form or fiche for seven (7) years.

CPS assigns each claim a unique claim number. Once the claim is in CPS, the system attempts to auto-adjudicate the claim. If the claim passes all edits, it is approved for payment and a check number is assigned. The 2002 claims auto-adjudication report showed that 46.8 percent of claims submitted are auto-adjudicated.

If a claim does not pass through the system edits, it is forwarded to a queue for manual adjudication. An error message is attached to the claim when it fails the system edits.

Coordination of Benefits (COB) claims are manually processed by COB specialists. Tracking of COB savings is done automatically. Any claims that are received that show other carrier information are investigated for COB.

Claims that are subject to Other Party Liability (OPL) are also manually processed by staff specializing in OPL claims. Pay and pursue procedures were implemented October 1, 1999. Prior to October 1, 1999, if a member did not return the multiple coverage inquiry, claims would be denied. Effective October 1, 1999, claims are pended for 30 days or until receipt of the multiple coverage inquiry. If a response is not received, the claim is released for payment. OPL processors check the system daily for claims approaching pay and pursue status. At 21 days, a phone call is placed to the member in an effort to expedite obtaining other coverage information.

Claims Review

During the examination period, total claims processed by each company were:

- Regence Blue Shield 20,095,174

- Asuris Northwest Health 647,033
- RegenceCare 584,605

The examiners randomly selected a sample of 450 claims. Seventy-five percent (75%) of the claims selected (330) were medical and dental claims and 25% were pharmacy claims (120). Twelve (12) claims were removed from the sample as they were claims for employees of the Companies. To ensure employee confidentiality, only two (2) claims department staff members are given system security rights to process employees' claims. The following is a breakdown of the sample selection by company:

Company	Medical/Dental	Pharmacy	Total
Regence Blue Shield	114	43	157
Asuris Northwest Health	100	39	139
RegenceCare	110	32	142
Total	**324**	**114**	**438**

Findings

The examiners noted the following processing errors during the claims review:

- The pharmacy and x-ray charges on one emergency room claim were paid at the extended network level. All other charges on the claim were paid at the higher in-network level. The Companies confirmed that the pharmacy and x-ray were processed incorrectly. An adjustment was entered on July 28, 2003, and an additional $16.02 was paid to the provider on August 6, 2003.
- One (1) claim had a diagnosis that was not appropriate to the member's gender. The Companies did not have that particular diagnosis flagged as a female specific diagnosis. The Companies placed a flag on that diagnosis on August 11, 2003 that requests a claims examiner to confirm the diagnosis and gender during the adjudication process.

During the course of the examination, the examiners discovered that pharmacy benefits are contractually excluded from coordination of benefits on the Companies' standard master contracts. During the claims review, the examiners found that pharmacy benefits were coordinated on one (1) pharmacy claim (OIC #391RX, Claim #0227965030000). Claims staff confirmed that pharmacy benefits are typically excluded from coordination of benefits. However, there is one (1) exception. A member can coordinate benefits between two (2) RBS plans if that member's primary plan has a prescription drug card copayment and the member's secondary plan pays prescription benefits under major medical. In that scenario, the member is allowed to submit the copayment amount for reimbursement from the secondary plan. Both primary and secondary coverage must be with RBS in order to receive this benefit.

Subsequent Event: The Companies standard group and individual contracts were revised effective July 1, 2004 to reflect any exceptions to benefits that may be excluded from

Coordination of Benefits provisions. The contracts were filed April 1, 2004 and approved by the OIC for a July 1, 2004 effective date.

The following Claims Standards passed without comment:

#	Claims Standard	Reference
1	The Company shall provide no less than urgent and emergency care to a child who does not reside in the Company's service area.	HCSC/HMO Reference RCW 48.01.235(3)
2	The Company shall not retrospectively deny coverage for care that had prior authorization.	HCSC/HMO Reference RCW 48.43.525(1)
3	The Company shall not deny an individual prescription drug claim that had prior authorization.	HCSC Reference RCW 48.44.465 HMO Reference RCW 48.46.535
4	The Company shall not deny benefits for any service performed by a denturist if the service performed was within the lawful scope of such person's license, and the agreement would have provided benefits if services were performed by a dentist.	HCSC Reference RCW 48.43.180, RCW 48.44.500 HMO Reference RCW 48.43.180, RCW 48.46.570
6	The denial of any claim must be communicated to the provider or facility with the specific reason the claim was denied.	HCSC/HMO Reference WAC 284-43-321(4)
7	The Company maintains a documented utilization review program with descriptions and conducts utilization review within the prescribed format defined.	HCSC/HMO Reference RCW 48.43.520, WAC 284-43-410
8	The Company administers Coordination of Benefits provisions as required.	HCSC/HMO Reference Chapter 284-51 WAC
9	All plans must include every category of provider.	HCSC/HMO Reference RCW 48.43.045, WAC 284-43-205

The following Claims Standards passed with comment:

#	Claims Standard	Reference
5	The Company pays or denies all claims according to the prescribed minimum standards.	HCSC/HMO Reference WAC 284-43-321(2)

Claims Standard #5:

The examiners found seven (7) clean claims were not paid within 30 days as required by WAC 284-43-321(2)(a)(i). The Companies claims processing system automatically included interest payments as required.

In addition, the examiners noted a procedure that is currently in place that could potentially cause the Companies to pay or deny claims outside the 60-day requirement of WAC 284-43-321(2)(a)(ii). One (1) claim reviewed was for a member whose group was delinquent in premium payment. The claim was denied with a code stating that coverage was not in effect on the date of service. Premium payment was received on the same date that the claim was denied. The claim was not paid until 83 days after the date of receipt. Claim payment included interest. The examiners asked for clarification of the procedure and learned that eligibility adjustments are only done every 60 days. When groups are cancelled for delinquent premium and the group is subsequently reinstated, the Companies' membership coordinator assigned to that group notifies the claims department to perform a history sweep on claims denied for no eligibility. However, this system-generated report is only run at 60-day intervals. This report reflects all claims previously denied for eligibility reasons. The Companies set the tolerance at 60 days to allow groups to submit all paperwork related to eligibility. The Companies were reviewing this practice while the examiners were on site. If the current procedure remains in place, interest payments will be required on any claims denied for eligibility reasons of this nature. See Appendix 3.

UNDERWRITING

Underwriting Manuals

The Company provided the examiners with copies of the following underwriting manuals and guidelines:

- Underwriting Policy Manual (January 2001)
- Medicare Supplement Medical Underwriting Procedures (July 2001)
- Underwriting Rating Manual for Merit Based Groups (January 2002)
- Underwriting Rating Manual for Experience Rated Groups (October 2001)

The examiners found that there were some policies in the Underwriting Policy Manual that did not correctly reflect mandated benefits.

- Waiting periods for newborn adoptive children were not accurately described. The policy stated that waiting periods for newborn adoptive children would be in effect unless the child was placed on the date of birth. The Companies informed the examiners that the original version of the Washington Underwriting Policy Manual used the Oregon manual as a template. This section was inadvertently carried over from the Oregon manual. The Companies stated the contract language will always

override instructions in the underwriting manuals. The examiners confirmed that the contract language is correct and follows statute. The examiners also noted that there were no underwriting or claims violations regarding this policy mandate.

Subsequent Event: The section was revised on July 26, 2003 to reflect language that complies with RCW 48.01.180(2), RCW 48.01.180(3), RCW 48.44.420(1) and RCW 48.46.490(1).

- The Companies offer vision benefits as a rider. The manual states that a group must have a minimum of five (5) enrollees in order to offer the benefit as a rider.

  Subsequent Event: The section was revised on July 26, 2003 to reflect that vision riders will be offered to groups of one (1) or more employees to comply with RCW 48.43.005(24).

- The manual did not clearly state the requirements and frequency for obtaining proof of incapacity and dependency for dependent children that have attained limiting age.

  Subsequent Event: The policy manual was revised on August 1, 2003 to state that proof of incapacity will be required within 31 days after the child's 25th birthday, and not more frequently than once per year after the child's 27th birthday to comply with RCW 48.44.200.

- The manual contained language that limited coverage under the Erin Act (RCW 48.43.115(3)(f)) to hospitalization only. The Companies informed the examiners that the original version of the Washington Underwriting Policy Manual used the Oregon manual as a template. This section was inadvertently carried over from the Oregon manual. The Companies stated the contract language will always override instructions in the underwriting manuals. The examiners confirmed that the contract language is correct and follows statute. The examiners also noted that there were no underwriting or claims violations regarding this policy mandate.

  Subsequent Event: The policy manual was revised on August 1, 2003 to state that newborn children are covered for 21 days from the date of birth under the contract if the female subscriber or subscriber's female spouse is eligible for maternity benefits under the contract.

Underwriting Process

Individual Underwriting Process

All individual applications are received by the Company through a dedicated post office box and are delivered directly to the Individual Underwriting Department.

The underwriting staff reviews each application. If the application is complete, all information from the application and standard health questionnaire is entered into the RBS computer system. The system is programmed to automatically score the standard health questionnaire and determine an applicant's eligibility for coverage. If the applicant meets the standard health questionnaire scoring requirements, the application is approved for coverage. A letter is then sent to the applicant with notification of the coverage effective date. A contract and member identification cards are ordered.

If the application is incomplete, a letter is sent to the applicant asking for additional information. If the requested information is not received within 45 days, a final letter is mailed to the applicant stating that the information has not been received and the file will be closed.

If the applicant's standard health questionnaire score is not acceptable, a letter is mailed to the applicant along with a copy of their scored questionnaire. The letter identifies the reason for the declination of coverage. The letter also offers the applicant the opportunity to appeal the underwriting decision. The declination letter refers the applicant to the Washington State Health Insurance Pool (WSHIP) for coverage.

Group Underwriting Process

The Companies' write group business in the following categories:

- Small groups: 1 – 50 employees
- Large groups: 51 – 150 employees
- Negotiated groups: 151+ employees

New groups submit a group master application, employee enrollment forms, and the first month's premium to the Companies. All paperwork required for enrollment must be received 15 days prior to the group's effective date. Incomplete enrollment submissions are returned to the group. Each new group is assigned a membership coordinator. The membership coordinator is responsible for loading the group into the Companies' computer system, confirming eligibility, and crediting prior coverage and pre-existing waiting periods. The coordinator also provides the group with its contract, member materials, and identification cards.

Underwriting File Review

Individual File Review

RBS submitted databases that included the following:

- 1,927 individual new issue applications effective in March 2002
- 332 individual reissued/inforce files effective in March 2002

- 1,307 individual declined applications from July 1, 2002 through December 31, 2002

Random samples of 50 files from each category were selected for review using ACL Software and NAIC Market Conduct Examiner Handbook guidelines. Two (2) of the 50 individual new issue applications were missing from the sample. The Companies were unable to produce the records, leaving 48 individual new issue applications that were reviewed by the examiners. The Companies' failure to provide the two (2) files is addressed in the General Examination Findings section of this report.

Three (3) of the individual reissued/inforce files were removed from the sample. Members requested contract reprints on two (2) files and a new contract was issued on one (1) file as a result of a product consolidation. RBS explained that its' computer system flags a file as a reissue when contracts are reprinted for any reason on an inforce policy. The examiners reviewed 47 reissued/inforce files.

Group File Review

The Companies provided the examiners with databases reflecting the number of commercial and negotiated groups that were inforce during the examination period. The examiners randomly selected a sample of 200 commercial groups for review using ACL Software and NAIC Market Conduct Examiner Handbook guidelines. Due to groups having dual coverage between RBS and RC, underwriting documentation for both plans was provided to the examiners. The following is a breakdown of the commercial group population and selected sample:

Commercial Groups

Company	Group Population	Sample Size	Number of Files Provided
Regence Blue Shield	14,116	100	117(1)
Asuris Northwest Health	1,243	50	50
RegenceCare	1,043	50	55(2)
Total	**16,402**	**200**	**222**

(1) Seventeen (17) groups from the RegenceCare sample had dual coverage with Regence Blue Shield. The Companies provided the additional files to the examiners for review.
(2) Five (5) groups from the Regence Blue Shield sample had dual coverage with RegenceCare. The Companies provided the additional files to the examiners for review.

The examiners randomly selected a sample of 50 negotiated files for review. Since the total population of negotiated group files for all three (3) Companies was 298, the examiners selected the sample based on the percentage of negotiated business held by each company. The following is a breakdown of the negotiated group population and selected sample:

Negotiated Groups

Company	Group Population	Sample Size	Number of Files Provided
Regence Blue Shield	271	43	41(1)
Asuris Northwest Health	11	2	2
RegenceCare	16	5	5
Total	**298**	**50**	**48**

(1) Two (2) groups were determined to be self-insured groups and outside the scope of the exam. These groups were removed from the sample.

The examiners reviewed the files to assure:

- Rates and benefits were appropriate to group demographics.
- Waiting periods for preexisting conditions were correctly applied and credited based on the size of the group.
- Members of groups were not unfairly denied coverage.
- Notifications of renewal action or termination were provided in a timely manner.
- The Companies' underwriting procedures and guidelines were applied consistently throughout the sample.

There were two (2) incomplete Underwriting files where underwriting data was missing: one from the Regence BlueShield Commercial sample, and one from the RegenceCare Commercial sample. These are addressed in the General Examination Findings section.

Findings

Underwriting Standard #13 is not applicable to this examination because there were no riders attached to the files reviewed.

The following Underwriting Standards passed without comment:

#	Underwriting Standard	Reference
1	**The Company complies with the prescribed requirements for enrollment and coverage of a child under the health plan of the child's parent.**	**HCSC Reference**
		RCW 48.01.235, RCW 48.44.212
		HMO Reference
		RCW 48.01.235, RCW 48.46.250

#	Underwriting Standard	Reference
3	**The Company may not reject an individual for health plan coverage in a large or small group based upon preexisting conditions of the individual. The Company may not deny, exclude, or limit coverage for an individual's preexisting health conditions. The Company shall accept any state resident within the group and within the Company's service area.**	**HCSC/HMO Reference** **RCW 48.43.025, RCW 48.43.035(1), WAC 284-43-720**
4	**Eligibility to purchase a health benefit plan must be extended to all small employers and small groups as defined in RCW 48.43.005(24).**	**HCSC/HMO Reference** **RCW 48.43.028**
5	**Dependent children cannot be terminated from an individual or group plan because of developmental disability or physical handicap.**	**HCSC Reference** **RCW 48.44.200, RCW 48.44.210** **HMO Reference** **RCW 48.46.320**
6	**All plans shall cover newborn infants and congenital anomalies from the moment of birth. The notification period and payment of required premium to the Company shall be no less than 60 days from the date of birth.**	**HCSC Reference** **RCW 48.44.212(1)** **HMO Reference** **RCW 48.46.250(1)**
7	**No plan may deny coverage solely on account of race, religion, national origin, or the presence of any sensory, mental, or physical handicap.**	**HCSC Reference** **RCW 48.44.220** **HMO Reference** **RCW 48.46.060(5), RCW 48.46.370**
8	**The Company may not refuse, cancel, or decline coverage solely because of a mastectomy or lumpectomy more than five (5) years prior.**	**HCSC Reference** **RCW 48.44.335** **HMO Reference** **RCW 48.46.285**
9	**Adoptive children shall be covered on the same basis as other dependents. The notification period and payment of required premium to the Company shall be no less than 60 days from the date of birth.**	**HCSC Reference** **RCW 48.44.420** **HMO Reference** **RCW 48.46.490**
11	**The Company shall provide written notice of its decision not to accept an individual's application for enrollment to both the applicant and WSHIP within 15 business days of receipt of a completed application.** *Individual Coverage only.*	**HCSC/HMO Reference** **RCW48.43.018(2)(b)**

#	Underwriting Standard	Reference
12	**All cancellations, denials, or non-renewals of an individual plan must be in writing and include the reason for such action.**	**HCSC Reference**
		RCW 48.44.260
		HMO Reference
		RCW 48.46.380
14	**The Company shall not impose a waiting period greater than 9 months for any preexisting conditions, and shall credit time covered under a prior plan toward the waiting period.** *Individual Coverage only.*	**HCSC/HMO Reference**
		RCW 48.43.012(3)

The following Underwriting Standards passed with comment:

#	Underwriting Standard	Reference
2	**The Company appropriately reduces preexisting condition exclusions, limitations, or waiting periods in its large group, small group and individual plans by applying time covered by the preceding health plan coverage.**	**HCSC Reference**
		RCW 48.43.015, WAC 284-43-710
10	**An individual is not required to complete the standard health questionnaire if the stated criteria are met.**	**HCSC/HMO Reference**
		RCW 48.43.018(1)

Underwriting Standard #2:
One (1) of 48 Individual New Issue files reviewed incorrectly applied the time covered by the preceding health plan to the spouse of the applicant, but correctly applied time covered by the preceding health plan to the applicant. (OIC #12, Policy 544507730)

Underwriting Standard #10:
One (1) of 50 Individual Declined files inappropriately requested completion of a health questionnaire for a newborn infant with three (3) days prior coverage even though the remaining members of the same family were accepted for coverage with prior coverage correctly documented. (OIC #40, Policy 246029049)

CONTRACTS AND MEMBER HANDBOOKS

The Companies submitted 684 contract filings to the OIC during the examination period. The breakdown of these filings is as follows:

Company	Negotiated	Large Group	Small Group	Individual
Regence Blue Shield	597	3	4	6
Asuris Northwest Health	60	1	3	1
RegenceCare	5	1	3	0
TOTAL	**662**	**5**	**10**	**7**

The examiners reviewed the contracts and member materials that were included in each of the files selected as part of the underwriting sample. The following were reviewed:

Company	Negotiated	Large Group	Small Group	Individual
Regence Blue Shield	41	1	2	6
Asuris Northwest Health	2	1	1	0
RegenceCare	5	1	1	0
TOTAL	**48**	**3**	**4**	**6**

The following Contract and Member Handbook Standards passed without comment:

#	Contract and Member Handbooks Standard	Reference
2	**All contracts must include exercise of conscience provisions.**	**HCSC/HMO Reference**
		RCW 48.43.065, WAC 284-43-800
3	**Enrollees are not prohibited from contracting for services outside the plan.**	**HCSC/HMO Reference**
		RCW 48.43.085
4	**Enrollees are allowed to contract for mental health services at enrollee's expense.**	**HCSC/HMO Reference**
		RCW 48.43.087
6	**Decisions concerning maternity care and services are to be made between the mother and the provider.**	**HCSC/HMO Reference**
		RCW 48.43.115
7	**An enrollee may receive benefits at a long term care facility if he/she was a resident prior to hospitalization.**	**HCSC/HMO Reference**
		RCW 48.43.125
8	**All plans must allow enrollees to select a primary care provider who is accepting new patients from a list of participating providers.**	**HCSC/HMO Reference**
		RCW 48.43.515, WAC 284-43-251
9	**All plans must include coverage for diabetes.**	**HCSC Reference**
		RCW 48.44.315
		HMO Reference
		RCW 48.46.272
10	**All plans must include coverage for mammograms.**	**HCSC Reference**
		RCW 48.44.325, WAC 284-44-046
		HMO Reference
		RCW 48.46.275
11	**All plans must include coverage for reconstructive breast surgery.**	**HCSC Reference**
		RCW 48.44.330
		HMO Reference
		RCW 48.46.280

#	Contract and Member Handbooks Standard	Reference
13	All plans must include provisions to assure that dependents shall have the right to continue coverage in the event of loss of eligibility by the principal enrollee.	HCSC Reference
		RCW 48.44.400
		HMO Reference
		RCW 48.46.480
14	All plans must provide coverage for the formula necessary for the treatment of phenylketonuria (PKU).	HCSC Reference
		RCW 48.44.440, WAC 284-44-450
		HMO Reference
		RCW 48.46.510, WAC 284-46-100
15	All plans shall offer optional coverage for the treatment of temporomandibular joint disorders (TMJ).	HCSC Reference
		RCW 48.44.460, WAC 284-44-042
		HMO Reference
		RCW 48.46.530, WAC 284-46-506
16	All group plans must contain, or incorporate by endorsement, provisions guaranteeing continuity of coverage.	HCSC/HMO Reference
		RCW 48.43.035(2), WAC 284-43-730(1)
18	All plans must offer substitution of home health care in lieu of hospitalization or institutionalization.	HCSC Reference
		RCW 48.44.320, WAC 284-44-500
		HMO Reference
		WAC 284-46-500
19	All plans that exclude or limit experimental and investigational prescriptions, treatments, services, or procedures must include a definition of experimental and investigational.	HCSC Reference
		WAC 284-44-043
		HMO Reference
		WAC 284-46-507
21	All group plans must offer supplemental coverage for mental health treatment. If mental health treatment is included, the specified statement as defined must be included in the contract.	HCSC Reference
		RCW 48.44.340, WAC 284-43-810
		HMO Reference
		RCW 48.46.290, WAC 284-43-810
22	All group plans shall provide benefits for the treatment of chemical dependency. All contract benefits for the treatment of chemical dependency must comply with the specified standards.	HCSC Reference
		RCW 48.44.240, Chapter 284-53 WAC
		HMO Reference
		RCW 48.46.350, Chapter 284-53 WAC

#	Contract and Member Handbooks Standard	Reference
23	An enrollee may pay premium directly to the health carrier in the event of a labor dispute.	HCSC Reference
		RCW 48.44.250
		HMO Reference
		RCW 48.46.360
24	All group plans must provide benefits for prenatal diagnosis of congenital disorders.	HCSC Reference
		RCW 48.44.344
		HMO Reference
		RCW 48.46.375
25	All group plans must include an offer to include an optional continuation provision.	HCSC Reference
		RCW 48.44.360
		HMO Reference
		RCW 48.46.440
26	All group plans must include a provision granting a person covered by the plan the right to obtain a conversion agreement upon termination of the person's eligibility.	HCSC Reference
		RCW 48.44.370, Chapter 284-52 WAC
		HMO Reference
		RCW 48.46.450, Chapter 284-52 WAC
27	All group plans must provide coverage for neurodevelopmental therapies for individuals age 6 and under.	HCSC Reference
		RCW 48.44.450
		HMO Reference
		RCW 48.46.520
28	Every health care service contract shall conform to the prescribed format standards and contain the prescribed contract standards.	HCSC Reference
		WAC 284-44-030, WAC 284-44-040
		HMO Reference
		None
29	All plans offered by a health care service contractor shall contain provisions stating that the services received from a registered nurse or advanced registered nurse practitioner will not be denied.	HCSC Reference
		WAC 284-44-045
		HMO Reference
		None
30	All health care service contract group plans shall offer coverage for chiropractic care on the same basis as any other care.	HCSC Reference
		RCW 48.43.515(5), RCW 48.44.310(1)
		HMO Reference
		None
31	A health care service contractor shall produce and provide certificates of coverage to the employer for distribution to each covered employee.	HCSC Reference
		WAC 284-44-050
		HMO Reference
		None

#	Contract and Member Handbooks Standard	Reference
32	**An individual plan must contain, or incorporate by endorsement, provisions guaranteeing continuity of coverage. *Individual Coverage Only***	**HCSC/HMO Reference** **RCW 48.43.038**
33	**All individual health benefit plans offered or renewed after October 1, 2000 shall include maternity and prescription drugs benefits. *Individual Coverage Only***	**HCSC/HMO Reference** **RCW 48.43.041**
34	**An individual may return an individual health care contract for a full refund within ten (10) days of its delivery if not satisfied with the contract for any reason. *Individual Coverage Only***	**HCSC Reference** **RCW 48.44.230** **HMO Reference** **RCW 48.46.340**

The following Contract and Member Handbook Standards passed with comment:

#	Contract and Member Handbooks Standard	Reference
12	**All plans shall waive preauthorization for mental health treatment if the member is involuntarily committed to a state mental hospital.**	**HCSC Reference** **RCW 48.44.342** **HMO Reference** **RCW 48.46.292**
17	**All plans that include pharmacy services coverage must include the required disclosure statement. *Effective July 1, 2001.***	**HCSC/HMO Reference** **WAC 284-43-815**

Contract and Member Handbooks Standard #12:

A brochure (MKTK-84 REV 5-00) that was provided to one (1) group with its member handbook instructs the member on the preauthorization procedures for obtaining mental health treatment and the Companies' relationship with Magellan Behavioral Health. It fails to address that preauthorization is not required if the member is involuntarily committed to a state mental hospital. When questioned, the Companies informed the examiners that preauthorization is not required by RBS for any level of inpatient care, whether it is involuntary or voluntary. However, the instructions and information provided are not clear to the member. The language implies that preauthorization is required for all mental health treatment.

Subsequent Event: The Companies ceased using the brochure in question on January 1, 2003.

Contract and Member Handbooks Standard #17:

Two (2) of the 61 contracts and member handbooks reviewed did not contain the pharmacy disclosure statement that is required by WAC 284-43-815. See Appendix 4.

The following Contract and Member Handbook Standards failed:

#	Contract and Member Handbooks Standard	Reference
1	All plans must provide female enrollees direct access to women's health care services.	HCSC/HMO Reference
		RCW 48.42.100, WAC 284-43-250
5	All plans shall cover emergency services necessary to screen and stabilize a covered person.	HCSC/HMO Reference
		RCW 48.43.093
20	If the health plan contains provisions for the reduction of benefits, the provisions shall comply with the Standards for Coordination of Benefits.	HCSC/HMO Reference
		Chapter 284-51 WAC

Contract and Member Handbooks Standard #1:
Seventeen (17) of the 61 contracts and handbooks reviewed did not contain any reference to women's direct access benefits as required by WAC 284-43-250(4). See Appendix 5.

Contract and Member Handbooks Standard #5:
All 61 contracts reviewed do not contain the required prudent layperson language. The contracts state "The sudden and unexpected onset of a condition or the exacerbation of an existing condition, requiring Medically Necessary care to safeguard the Member's life or limb immediately after the onset of the emergency. For the purpose of Benefit determination, consideration will be given by the Company to the symptoms of the condition and to the actions that would have been taken by a prudent person under such circumstances." RCW 48.43.093(1)(a) stipulates that "a health carrier shall cover emergency services necessary to screen and stabilize a covered person if a prudent layperson action reasonably would have believed that an emergency medical condition existed." The RCW states that the "prudent layperson" determines when emergency medical services are necessary – not the carrier.

Subsequent Event: The Companies revised the standard group and individual plan contracts to include the prudent person language within the emergency definition. The contracts were filed April 1, 2004 and were approved by the OIC for a July 1, 2004 effective date.

Contract and Member Handbooks Standard #20:
All 61 contracts reviewed do not include the correct definition of allowable expense. The definition in WAC 284-51-050(1)(a) is to be used verbatim in the COB sections of all contracts. The Rates and Forms Division of the OIC instructed the Companies to correct the definition in November 2002. The Companies responded that the correct language would appear in its January 2003 filings.

Subsequent Event: The Companies revised the standard and individual contracts to reflect the correct definition of "allowable expense" as defined by WAC 284-51-050(1)(a). The contracts were filed September 10, 2002 and were approved by the OIC for a January 1, 2003 effective date.

PROVIDER CONTRACTS

Provider Contracting Process

Provider contracting is handled by Provider Network Management (PNM). PNM sends a contract and credentialing application to new providers. When returned by the provider, the system is updated. The provider's file is given to the appropriate Provider File Analyst for rider number assignments and then returned to the Contract Analyst who mails a welcome letter and packet along with a copy of the countersigned contracts. This usually occurs within ten days of the completion of the credentialing process. The signed contract is filed in the Provider's file and returned to the File Room.

Provider Manuals

The Company provided copies of the Regence Blue Shield Practitioner and Organizational Provider Manual (Revision Date: July 2001) and the Regence Dental Provider Manual, which has two different versions; 2001 and 2002.

The examiners reviewed the Regence Blue Shield Practitioner and Organizational Provider Manual (Revision Date: July 2001). There is one (1) section within the manual of concern:

- The section titled Boeing Plans, Appeals, Boeing Traditional and Selections Medical Plans states, "There are three levels of standard appeal. At each level, members or their representatives may appeal within 60 days of receipt of a denial. Notification of the outcome will be made within **40** days of receipt." WAC 284-43-620(1**)** states: "The carrier must reconsider the adverse determination and notify the covered person within **fourteen** days of receipt of the appeal unless the carrier notifies the covered person that an extension is necessary to complete the appeal; however, the extension cannot delay the decision beyond **thirty** days of the request for appeal, without the informed, written consent of the covered person." (Emphasis added.)

The examiners reviewed the Regence Dental Provider Manual. There are two different versions: 2001 and 2002. The examiners had no comments about the dental provider manuals.

Provider Directories

There were 12 provider directories reviewed. The directories indicate that the Companies operate within the stated territories of operations. There were no problems or violations in the Provider Directories.

Provider Contract Review

There were 80,272 providers (58,855 HCSC and 21,417 HMO) contracted with the Companies during the examination period. A random sample of 100 provider contract files was selected.

Thirteen (13) HCSC and five (5) HMO provider contract forms contained language that stated that the Company is registered as a Health Care Service Contractor or Health Maintenance Organization and as such is not subject to laws specifically applicable to insurance. This was addressed in letters from the Rates and Forms Division of the OIC on July 22, 2002 and August 2, 2002. The OIC communicated to the Companies that RCW 48.01.053 defines an "issuer" as a "…health maintenance organization and health care service contractor." The letters advised the Companies that the language in the form submitted is not correct and needed to be changed. As of the conclusion of the examination, the language had not been changed as instructed by the Rates and Forms Division.

Subsequent Event: The Companies revised the provider contracts and each contains appropriate reference to the Company's status as an HCSC or HMO and the status as an issuer. The contracts were filed November 4, 2002, approved by the OIC on November 13, 2002, and effective December 1, 2002. The Companies began using the newly filed contracts in 2003.

Findings

There were eight (8) HCSC provider contract forms and one (1) HMO form that did not contain the correct definition of emergency medical condition.

The following Provider Contract Standards passed without comment:

#	Provider Contract Standard	Reference
1	**No individual health care provider may be required by law or contract in any circumstances to participate in the provision of a specific service if they object to so doing for reason of conscience or religion.**	**HCSC/HMO Reference** **RCW 48.43.065(2)(a)**
4	**Provider contracts shall contain provisions obligating the provider to provide services for the duration of the period after an HCSC's/HMO's insolvency for which premium payment has been made and until the enrolled participant's discharge from inpatient facilities.**	**HCSC Reference** **RCW 48.44.055(2)** **HMO Reference** **RCW 48.46.245(2)**
5	**An HMO may not discriminate against a qualified doctor of osteopathic medicine and surgery solely because that practitioner was board certified or eligible under an approved osteopathic certifying board instead of under an approved medical certifying board.**	**HCSC Reference** **None** **HMO Reference** **RCW 48.46.575**

The following Provider Contract Standards failed:

#	Provider Contract Standard	Reference
2	**All provider contracts shall contain language holding the enrolled participant harmless should the Company fail to pay for health care services.**	**HCSC Reference**
		RCW 48.44.020(4), WAC 284-43-320(2)
		HMO Reference
		RCW 48.46.243(1) and (4), and WAC 284-43-320(2)
3	**All provider contract forms must be filed with and approved by the OIC prior to use.**	**HCSC Reference**
		RCW 48.44.070, WAC 284-43-330
		HMO Reference
		RCW 48.46.243(3), WAC 284-43-330
6	**All provider contract forms must contain and adhere to the prescribed standards.**	**HCSC/HMO Reference**
		WAC 284-43-320 through WAC 284-43-340

Provider Contract Standard # 2:
There were three (3) of 38 HCSC provider contract forms and one (1) of 11 HMO provider contract forms that failed to contain the required hold harmless language. See Appendix #6.

Subsequent Event: The Companies revised the provider contracts to assure compliance with the hold harmless language requirements. The contracts were filed November 4, 2002, approved by the OIC on November 13, 2002, and effective December 1, 2002. The Companies began using the newly filed contracts in 2003.

Provider Contract Standard #3:
There were 23 of 38 HCSC provider contract forms and eight (8) of 11 HMO provider contract forms that were not filed with the OIC prior to use. See Appendix #7.

Provider Contract Standard # 6:
There were 15 HCSC provider contract forms and three (3) HMO forms that require the terminated provider to notify his/her patients of the provider's termination. WAC 284-43-320(7) requires that the **carrier** make notification to the covered persons.

There were 21 HCSC provider contract forms and seven (7) HMO forms that restricted dispute resolution to arbitration or mediation. WAC 284-43-322(4) states that a carrier may not require alternative dispute resolution to the exclusion of judicial remedies. The examiners also noted that the Regence Blue Shield Practitioner and Organization Provider Manual (Revision Date: July 2001) advises the provider to refer to his contract for dispute resolution methods. The

manual also excludes resolution through the judicial system as a method of dispute resolution. See Appendix 8.

Subsequent Event: The Companies revised the provider contracts to assure compliance with the prescribed provider contract standards. The contracts were filed November 4, 2002, approved by the OIC on November 13, 2002, and effective December 1, 2002. The Companies began using the newly filed contracts in 2003.

INSTRUCTIONS

	INSTRUCTIONS	PAGE #
1	Based on benefit summaries reviewed by the examiners that illustrated discriminatory payment levels for groups under five members, the Companies are instructed to audit and reprocess all maternity claims since 7/1/00 for BIAW members to assure that benefits were paid at 100% in network and 70% out of network.	12
2	The Companies are instructed to maintain a complete file of all advertising material.	13
3	Based on procedures described in the Companies' underwriting manual, the Companies are instructed to review and reprocess any claims incurred that may have been inappropriately denied for adoptive children and for newborns covered by the Erin Act.	18
4	The Companies are instructed to revise all member handbook documents to clearly state that female enrollees are provided direct access to women's health services.	28
5	The Companies are instructed to revise all contract documents to include the prudent person language as defined by statute.	28
6	The Companies are instructed to revise all contract documents to include the correct definition of allowable expense for Coordination of Benefits.	28
7	As previously instructed by the OIC's Rates and Forms Division, the Companies are instructed to amend the provider contracts to accurately reflect that, as an HCSC or HMO, the companies meet the definition of an issuer and are subject to laws applicable to insurance.	30
8	The Companies are instructed to include hold harmless language in their provider contracts.	31
9	The Companies are instructed to file provider contract forms with the OIC prior to use.	31
10	The Companies are instructed to notify subscribers regarding terminated providers rather than requiring the providers to notify the patients.	31
11	The Companies are instructed to remove the language in the provider contract forms that require alternative dispute resolution to the exclusion of judicial remedies.	31

RECOMMENDATIONS

	RECOMMENDATIONS	PAGE #
1	It is recommended that the Companies maintain accurate and complete accounts, records, documents, and files to facilitate future examinations.	11
2	It is recommended that the Companies use no advertising that omits information with the effect of misleading or deceiving purchasers or prospective purchasers as to the nature or extent of any policy benefit payable, or misrepresentation of the benefits or advantages of the contract.	12
3	It is recommended that the Companies amend contracts to clearly reflect any exceptions to benefits that may be excluded from Coordination of Benefits provisions.	15
4	It is recommended that the Companies pay 95% of clean claims within 30 days, pay or deny 95% of all claims within 60 days, and pay interest on any undenied claims more than 61 days old.	16
5	It is recommended that the Companies correctly apply the time covered by a previous health plan to the preexisting condition exclusions, limitations, or waiting periods.	23
6	It is recommended that the Companies not require completion of the standard health questionnaire if the stated criteria are met.	23
7	It is recommended that the Companies revise all contract documents to include the waiver of preauthorization for mental health treatment if a member is involuntarily committed to a state hospital.	27
8	It is recommended that the Companies include the required disclosure statement with all plans that include pharmacy services coverage.	27
9	It is recommended that the Companies amend the provider manual(s) to correctly state the time requirements regarding appeal notification.	29

SUMMARY OF STANDARDS

Company Operations and Management:

#	STANDARD	PAGE	PASS	FAIL
1	The Company is required to be registered with the Office of Insurance Commissioner prior to acting as a health care service contractor or health maintenance organization in the State of Washington. Reference: RCW 48.44.015(1), RCW 48.46.027(1).	10	X	
2	The Company is required to report to the OIC any changes to the registration documents, including Articles of Incorporation, Bylaws, and Amendments at the same time as submitting such documents to the Secretary of State. Reference: RCW 48.44.013, RCW 48.46.012.	10	NA	
3	At least one-third of the HMO's board of directors is made up of consumers who are representative of the enrolled population. Reference: RCW 48.46.070(1)	10	X	

General Examination Findings:

#	STANDARD	PAGE	PASS	FAIL
1	The Company does business in good faith, and practices honesty and equity in all transactions. Reference: RCW 48.01.030.	10	X	
2	The Company facilitates the examination process by providing its accounts, records, documents and files to the examiners upon request. Reference: Reference: RCW 48.44.145(2), RCW 48.46.120(2).	11	X	
3	The Company may not discourage members from contacting the OIC and may not discriminate against those members that do contact the OIC. Reference: WAC 284-30-572(2).	11	X	

Advertising:

#	STANDARD	PAGE	PASS	FAIL
1	The Company cannot advertise a plan to prevent illness or promote health unless a) the clinical preventive benefits are the same as the basic health plan; b) it monitors and reports annually to enrollees on standards of health care and satisfaction of enrollees; c) it makes available its plan to identify and manage the most prevalent diseases within its enrolled population on request. Reference: RCW 48.43.510(5), WAC 284-43-820(5).	12	X	
2	No advertising may contain any false, deceptive or misleading information. Reference: RCW 48.44.110, RCW 48.46.400.	12	X	

#	STANDARD	PAGE	PASS	FAIL
3	The Company cannot make misleading comparisons with other companies to induce the consumer to change from another HCSC or HMO. Reference: RCW 48.44.140, RCW 48.46.410.	12	X	
4	The Company complies with the Washington Disability Insurance Advertising Regulations. Reference: WAC 284-50-010 through WAC 284-50-230.	12	X	
5	The Company maintains a complete advertising file. Reference: WAC 284-50-200.	13		X
6	The Company must comply with all health plan disclosures as required by regulation. Reference: WAC 284-43-820(1) through WAC 284-43-820(3).	12	X	
7	The Company cannot misrepresent the terms, benefits, or advantages of the contract. Reference: RCW 48.44.120, RCW 48.46.060(2) and (3), WAC 284-50-050.	13	X	
8	A Health Care Service Contractor cannot guarantee future dividends or future refunds except in group contracts with an experience refund provision. Reference: RCW 48.44.130.	12	X	
9	No Health Maintenance Organization may use the words "insurance", "casualty", "surety" or "mutual" to describe itself in its advertising materials. Reference: RCW 48.46.110(1).	12	X	

Claims:

#	STANDARD	PAGE	PASS	FAIL
1	The Company shall provide no less than urgent and emergent care to a child who does not reside in the Company's service area. Reference: RCW 48.01.235(3).	16	X	
2	The Company shall not retrospectively deny emergency or nonemergency care that had prior authorization. *Effective July 1, 2001.* Reference: RCW 48.43.525(1).	16	X	
3	The Company shall not retrospectively deny an individual prescription drug claim that had prior authorization. Reference: RCW 48.44.465, RCW 48.46.535.	16	X	
4	The Company shall not deny benefits for any service performed by a denturist if the service performed was within the lawful scope of such person's license, and the agreement would have provided benefits if services were performed by a dentist. Reference: RCW 48.43.180, RCW 48.44.500, RCW 48.46.570.	16	X	
5	The Company pays or denies all claims according to the prescribed minimum standards. *Effective November 11, 1999.* Reference: WAC 284-43-321(2).	16	X	

#	STANDARD	PAGE	PASS	FAIL
6	The denial of any claim must be communicated to the provider or facility with the specific reason the claim was denied. Reference: WAC 284-43-321(4).	16	X	
7	The Company maintains a documented utilization review program with descriptions and conducts utilization review within the prescribed format defined. Reference: RCW 48.43.520, WAC 284-43-410.	16	X	
8	The Company administers Coordination of Benefits provisions as required. Reference: Chapter 284-51 WAC.	16	X	
9	All plans must include every category of provider. Reference: RCW 48.43.045, WAC 284-43-205.	16	X	

Underwriting:

#	STANDARD	PAGE	PASS	FAIL
1	The Company complies with the prescribed requirements for enrollment and coverage of a child under the health plan of the child's parent. Reference: RCW 48.01.235, RCW 48.44.212, RCW 48.46.250.	21	X	
2	The Company appropriately reduces preexisting condition exclusions, limitations, or waiting periods in its large group, small group and individual plans by applying time covered by the preceding health plan coverage. Reference: RCW 48.43.015, WAC 284-43-710.	23	X	
3	The Company may not reject an individual for health plan coverage in a large or small group based upon preexisting conditions of the individual. The Company may not deny, exclude, or limit coverage for an individual's preexisting health conditions. The Company shall accept any state resident within the group and within the Company's service area. Reference: RCW 48.43.025, RCW 48.43.035(1), WAC 284-43-720.	22	X	
4	Eligibility to purchase a health benefit plan must be extended to all small employers and small groups as defined in RCW 48.43.005(24). Reference: RCW 48.43.028.	22	X	
5	Dependent children cannot be terminated from an individual or group plan because of developmental disability or physical handicap. Reference: RCW 48.44.200, RCW 48.44.210, RCW 48.46.320.	22	X	
6	All plans shall cover newborn infants and congenital anomalies from the moment of birth. The notification period and payment of required premium to the Company shall be no less than 60 days from the date of birth. Reference: RCW 48.44.212(1), RCW 48.46.250(1).	22	X	

#	STANDARD	PAGE	PASS	FAIL
7	No plan may deny coverage solely on account of race, religion, national origin, or the presence of any sensory, mental, or physical handicap. Reference: RCW 48.44.220. RCW 48.46.060(5), RCW 48.46.370.	23	X	
8	The Company may not refuse, cancel, or decline coverage solely because of a mastectomy or lumpectomy more than five (5) years prior. Reference: RCW 48.44.335, RCW 48.46.285.	22	X	
9	Adoptive children shall be covered on the same basis as other dependents. The notification period and payment of required premium to the Company shall be no less than 60 days from the date of birth. Reference: RCW 48.44.420, RCW 48.46.490	22	X	
10	An individual is not required to complete the standard health questionnaire if the stated criteria are met. Reference: RCW 48.43.018(1).	22	X	
11	The Company shall provide written notice of its decision not to accept an individual's application for enrollment to both the applicant and WSHIP within 15 business days of receipt of a completed application. *Individual Coverage only.* Reference: RCW 48.43.018(2)(b).	22	X	
12	All cancellations, denials, or non-renewals of an individual plan must be in writing and include the reason for such action. Reference: RCW 48.44.260, RCW 48.46.380.	23	X	
13	A rider will be cancelled upon application by the enrollee if, at least five (5) years after its issuance, no health care services have been received by the enrollee for the condition specified in the rider. *Individual Coverage only.* Reference: RCW 48.44.430, RCW 48.46.500.	21	NA	
14	The Company shall not impose a waiting period greater than 9 months for any preexisting conditions, and shall credit time covered under a prior plan toward the waiting period. *Individual Coverage only.* Reference: RCW 48.43.012(3).	23	X	

Contracts and Member Handbooks:

#	STANDARD	PAGE	PASS	FAIL
1	All plans must provide female enrollees direct access to women's health care services. Reference: RCW 48.42.100, WAC 284-43-250.	28		X
2	All contracts must include exercise of conscience provisions. Reference: RCW 48.43.065, WAC 284-43-800.	24	X	
3	Enrollees are not prohibited from contracting for services outside the plan. Reference: RCW 48.43.085.	24	X	

#	STANDARD	PAGE	PASS	FAIL
4	Enrollees are allowed to contract for mental health services at enrollee's expense. Reference: RCW 48.43.087.	24	X	
5	All plans shall cover emergency services necessary to screen and stabilize a covered person. Reference: RCW 48.43.093.	28		X
6	Decisions concerning maternity care and services are to be made between the mother and the provider. Reference: RCW 48.43.115.	24	X	
7	An enrollee may receive benefits at a long term care facility if he/she was a resident prior to hospitalization. Reference: RCW 48.43.125.	24	X	
8	All plans must allow enrollees to select a primary care provider who is accepting new patients from a list of participating providers. Reference: RCW 48.43.515, WAC 284-43-251.	24	X	
9	All plans must include coverage for diabetes. Reference: RCW 48.44.315, RCW 48.46.272.	24	X	
10	All plans must include coverage for mammograms. Reference: RCW 48.44.325, RCW 48.46.275, WAC 284-44-046.	24	X	
11	All plans must include coverage for reconstructive breast surgery. Reference: RCW 48.44.330, RCW 48.46.280.	24	X	
12	All plans shall waive preauthorization for mental health treatment if the member is involuntarily committed to a state mental hospital. Reference: RCW 48.44.342, RCW 48.46.292.	27	X	
13	All plans must include provisions to assure that dependents shall have the right to continue coverage in the event of loss of eligibility by the principal enrollee. Reference: RCW 48.44.400, RCW 48.46.480.	25	X	
14	All plans must provide coverage for the formula necessary for the treatment of phenylketonuria (PKU). Reference: RCW 48.44.440, RCW 48.46.510, WAC 284-44-450, WAC 284-46-100.	25	X	
15	All plans shall offer optional coverage for the treatment of temporomandibular joint disorders (TMJ). Reference: RCW 48.44.460, RCW 48.46.530, WAC 284-44-042, WAC 284-46-506.	25	X	
16	All group plans must contain, or incorporate by endorsement, provisions guaranteeing continuity of coverage. Reference: RCW 48.43.035(2), WAC 284-43-730(1).	25	X	
17	All plans that include pharmacy services coverage must include the required disclosure statement. *Effective July 1, 2001.* Reference: WAC 284-43-815.	27	X	

#	STANDARD	PAGE	PASS	FAIL
18	All plans must offer substitution of home health care in lieu of hospitalization or institutionalization. Reference: RCW 48.44.320, WAC 284-44-500, WAC 284-46-500.	25	X	
19	All plans that exclude or limit experimental and investigational prescriptions, treatments, services, or procedures must include a definition of experimental and investigational. Reference: WAC 284-44-043, WAC 248-46-507.	25	X	
20	If the health plan contains provisions for the reduction of benefits, the provisions shall comply with the Standards for Coordination of Benefits. Reference: Chapter 284-51 WAC.	28		X
21	All group plans must offer supplemental coverage for mental health treatment. If mental health treatment is included, the specified statement as defined must be included in the contract. Reference: RCW 48.44.340, RCW 48.46.290, WAC 284-43-810.	25	X	
22	All group plans shall provide benefits for the treatment of chemical dependency. All contract benefits for the treatment of chemical dependency must comply with the specified standards. Reference: RCW 48.44.240, RCW 48.46.350, Chapter 284-53 WAC.	25	X	
23	An enrollee may pay premium directly to the health carrier in the event of a labor dispute. Reference: RCW 48.44.250, RCW 48.46.360.	26	X	
24	All group plans must provide benefits for prenatal diagnosis of congenital disorders. Reference: RCW 48.44.344, RCW 48.46.375.	26	X	
25	All group plans must include an offer to include an optional continuation provision. Reference: RCW 48.44.360, RCW 48.46.440.	26	X	
26	All group plans must include a provision granting a person covered by the plan the right to obtain a conversion agreement upon termination of the person's eligibility. Reference: RCW 48.44.370, RCW 48.46.450, Chapter 284-52 WAC.	26	X	
27	All group plans must provide coverage for neurodevelopmental therapies for individuals age 6 and under. Reference: RCW 48.44.450, RCW 48.46.520.	26	X	
28	Every health care service contract shall conform to the prescribed format standards and contain the prescribed contract standards. Reference: WAC 284-44-030, WAC 284-44-040.	26	X	

#	STANDARD	PAGE	PASS	FAIL
29	All plans offered by a health care service contractor shall contain provisions stating that the services received from a registered nurse or advanced registered nurse practitioner will not be denied. Reference: WAC 284-44-045.	26	X	
30	All health care service contractor group plans shall offer coverage for chiropractic care on the same basis as any other care. Reference: RCW 48.43.515(5), RCW 48.44.310(1).	26	X	
31	A health care service contractor shall produce and provide certificates of coverage to the employer for distribution to each covered employee. Reference: WAC 284-44-050.	26	X	
32	An individual plan must contain, or incorporate by endorsement, provisions guaranteeing continuity of coverage. *Individual Coverage Only*. Reference: RCW 48.43.038.	27	X	
33	All individual health benefit plans offered or renewed after October 1, 2000 shall include maternity and prescription drugs benefits. *Individual Coverage Only*. Reference: RCW 48.43.041.	27	X	
34	An individual may return an individual health care contract for a full refund within ten (10) days of its delivery if not satisfied with the contract for any reason. *Individual Coverage Only*. Reference: RCW 48.44.230, RCW 48.46.340.	27	X	

Provider Contracts:

#	STANDARD	PAGE	PASS	FAIL
1	No individual health care provider may be required by law or contract in any circumstances to participate in the provision of a specific service if he/she object to so doing for reason of conscience or religion. Reference: RCW 48.43.065(2)(a)	30	X	
2	All provider contracts shall contain language holding the enrolled participant harmless should the Company fail to pay for health care services. Reference: RCW 48.44.020(4), RCW 48.46.243(1) and (4), WAC 284-43-320(2).	31		X
3	All provider contract forms must be filed with and approved by the OIC prior to use. Reference: RCW 48.44.070, RCW 48.46.243(3), WAC 284-43-330.	31		X
4	Provider contracts shall contain provisions obligating the provider to provide services for the duration of the period after an HCSC's/HMO's insolvency for which premium payment has been made and until the enrolled participant's discharge from inpatient facilities. Reference: RCW 48.44.055(2), RCW 48.46.245(2).	30	X	

#	STANDARD	PAGE	PASS	FAIL
5	An HMO may not discriminate against a qualified doctor of osteopathic medicine and surgery solely because that practitioner was board certified or eligible under an approved osteopathic certifying board instead of under an approved medical certifying board. Reference: RCW 48.46.575.	30	X	
6	All provider contract forms must contain and adhere to the prescribed standards. Reference: WAC 284-43-320 through WAC 284-43-340.	31		X

APPENDIX 1

General Examination Findings Standard #2:

The Company facilitates the examination process by providing its accounts, records, documents and files to the examiners upon request. Reference: RCW 48.03.030(1), RCW 48.44.145(2), RCW 48.46.120(2).

OIC #	Policy #	Type	Comments
1		Individual New Issue	File missing from Sample
41		Individual New Issue	File missing from Sample

APPENDIX 2

Advertising Standard #5:

The Company maintains a complete advertising file. Reference: WAC 284-50-200.

The following advertising items were not included in the Company's advertising file:

OIC #	Company Form # Print Date	Item/Description
52	No form # Dec 18, 2002	Asuris NW Transition letter, 1 generic sample & 47 "live" groups *(CD-Rom)*
53	No form #, No date	Delinquency reminder – RBS *(CD-Rom)*
54	No form #, No date	Delinquency reminder – RNWH *(CD-Rom)*
55	No form #, July 2002	Department of Labor Claim Rule – Quick Facts cover letter – RNWH *(CD-Rom)*
56	No form #,July 2002	Department of Labor Claim Rule – Quick Facts cover letter – RBS *(CD-Rom)*
57	No form #, Aug 2002	HIPAA members final – Dec renewals letter *(CD-Rom)*
58	No form #,April 29, 2002	Out-of-state Par Pharmacy changes *(CD-Rom)*
59	No form #, April 15, 2002	Out-of-state Par Pharmacy changes *(CD-Rom)*
60	No form #, No date	Department of Labor Claim Rule – Quick Facts flyer *(CD-Rom)*
61	No form #,No date	Department of Labor Claim Rule – Quick Facts flyer *(CD-Rom)*
62	HO-21 Rev 11/01	Recommended Immunizations Schedule for Children 2001 *(paper doc)*
63	MKTK-166 Rev 2/02	Member Health Care Guidelines – Government Programs *(paper doc)*
64	HO-26 Rev 11/01	Primary Care Directory of Providers – Healthy Options *(paper doc)*

OIC #	Company Form # Print Date	Item/Description
65	HO-2 Rev 11/01	A Quick & Easy Guide – Benefits – Healthy Options *(paper doc)*
66	HO-28 Rev 11/01	Congratulations on your New Arrival *(paper doc)*
67	HO-63 Rev 1/02	Call your Doctor right away if you…. *(paper doc)*
69	MKTK-166 Rev 08/02	Member Health Care Guidelines *(paper doc)*
70	HO-2 Rev 10/02	A Quick & Easy Guide – Benefits – Healthy Options *(paper doc)*

APPENDIX 3

Claims Standard #5: The Company pays or denies all claims according to prescribed minimum standards. *Effective November 11, 1999.* Reference: WAC 284-43-321(2)

WAC 284-43-321(2)(a)(i): Ninety-five percent of the monthly volume of clean claims shall be paid within thirty days of receipt.

OIC ID #	Company Claim #	# of Days to Pay/Deny
RBS #42	0229634482800	35
RBS #77	0227432657700	50
RBS #84	0227532292900	49
RC #227	0228831013400	43
RC #239	0230431058300	34
RC #240	0227631005200	55
RC #298	0229132037200	40
RC#252	0227631006000	83

APPENDIX 4

Contract and Member Handbook Standard #17:
All plans that include pharmacy services coverage must include the required disclosure statement. *Effective July 1, 2001.* Reference: WAC 284-43-815.

The following files did not include the required pharmacy disclosure statement:

OIC #	Policy #	Type
N43	097152	RBS Negotiated Contract
C-7, C-11	301637, 101113	Small Group Contract / Form # RBS-48

APPENDIX 5

Contract and Member Handbook Standard #1:
All plans must provide female enrollees direct access to women's health care services. Reference: RCW 48.42.100, WAC 284-43-250.

The following files did not contain the required reference to direct access to women's health care services:

OIC #	Policy #	Type
N4	500805	RBS Negotiated Contract
N11	015744	RBS Negotiated Contract
N12	302450	RBS Negotiated Contract
N20	022150	RBS Negotiated Contract
N21	302457	RBS Negotiated Contract
N23	302458	RBS Negotiated Contract
N26	033863	RBS Negotiated Contract
N30	039204	RBS Negotiated Contract
N31	045926	RBS Negotiated Contract
N32	090181	RBS Negotiated Contract
N33	303965	RBS Negotiated Contract
N34	090025	RBS Negotiated Contract
N35	047421	RBS Negotiated Contract
N36	303165	RBS Negotiated Contract
N43	097152, 097154	RBS Negotiated Contract
ANH-N2	049031	ANH Negotiated Contract
C50	031008	RBS Large Group Contract

APPENDIX 6

Provider Contract Standard # 2:
All provider contracts shall contain language holding the enrolled participant harmless should the Company fail to pay for health care services. Reference: RCW 48.44.020(4), RCW 48.46.243(1) and (4), WAC 284-43-320(2).

The following provider contracts failed to contain the required hold harmless language:

OIC ID #	Form Number
18 (HCSC)	FacAgr (4/2000) Revised 4-24-2000 2000GRPagr
82 (HCSC)	Regence BlueShield Magellan Behavioral Health Agreement (No #)
83 (HCSC)	Diversified Pharmaceutical Services Inc. Pharmaceutical Services Agreement (No #)
105 (HMO)	Regence Care Magellan Behavioral Health Agreement (No #)

APPENDIX 7

Provider Contract Standard #3:

All provider contracts must be filed with and approved by the OIC prior to use. Reference: RCW 48.44.070, RCW 48.43.243(3), WAC 284-43.330.

OIC ID #	Form Number	Amendment Not Filed/Approved	Contract Not Filed/Approved
1 (HCSC)	2010/wd/agrmnts/oicrbs20000ldagr1	X	
2 (HCSC)	2010\wd\agrmnts\rwhpprvk		X
9 (HCSC)	2010\wd\agrmnts\rbsclag		X
10 (HCSC)	2010\wd\agrmnts\clnagrvm		X
11 (HCSC)	2010\wd\agrmnts\clnagr95		X
18 (HCSC)	FacAgr (4/2000) Revised 4-24-2000 2000GRPagr		X
	Amendment combining RBA & NWMB	X	
19 (HCSC)	2010\wd\agrmnts\rbsppoa3		X
25 (HCSC)	2010\wd\agrmnts\95hoshar		X
26 (HCSC)	2010\wd\agrmnts\rbshar		X
27 (HCSC)	2010\wd\agrmnts\rbshspm		X
29 (HCSC)	2010\wd\agrmnts\rwhclnk		X
32 (HCSC)	92PARMD002 2010/agreements/phys.agreea		X
45 (HCSC)	2010\wd\agrmnts\rbsprag		X
51 (HCSC)	TRG Participating Pharmacy Agreement		X
52 (HCSC)	The Regence Group Participating Independent Pharmacy Agreement		X
54 (HCSC)	rbsprag6		X
66 (HCSC)	2010\wd\agrmnts\rwhunshk		X
74 (HCSC)	RBS Participating Dental Provider Agreement (No #)		X
81 (HCSC)	King County Medical Blue Shield Contract w/ Green Spring Health Services (No #)		X
82 (HCSC)	Regence BlueShield Magellan Behavioral Health Agreement (No #)		X
83 (HCSC)	Diversified Pharmaceutical Services Inc. Pharmaceutical Services Agreement (No #)		X
84 (HCSC)	MSA TRG January 1, 2002		X
85 (HMO)	2010\wd\agrmnts\oicrc2000oldagr		X
87 (HMO)	HMO Washington Participating Managed		X

OIC ID #	Form Number	Amendment Not Filed/Approved	Contract Not Filed/Approved
	Group Practice Agreement (No #)		
88 (HMO)	2010\wd\agrmnts\rcpragr1		X
89 (HMO)	2010\wd\agrmnts\rcmgp		X
96 (HMO)	2010\wd\agrmnts\highcom		X
103 (HMO)	w/1010/agrmnts/rxagr99		X
104 (HMO)	1010\wd\agrmnts\parrx1b		X
105 (HMO)	Regence Care Magellan Behavioral Health Agreement (No #)		X

APPENDIX 8

Provider Contract Standard # 6:
All provider contracts must contain and adhere to the prescribed standards. Reference: WAC 284-43-320 through WAC 284-43-340.

WAC 284-43-320(7): The health carrier shall make a good faith effort to assure that written notice of a termination within fifteen working days of receipt or issuance of a notice of termination is provided to all covered persons who are patients seen on a regular basis by the provider whose contract is terminating, irrespective of whether the termination was for cause or without cause.

The following provider contracts required the terminated provider to notify his/her patient regarding termination:

OIC ID #	Form Number
1 (HCSC)	2010/wd/qgrmnts/rbsprag5
3 (HCSC)	2010/wd/qgrmnts/rbsprag3
7 (HCSC)	2010\wd\agrmnts\rbsclag3
9 (HCSC)	2010\wd\agrmnts\rbsclag
17 (HCSC)	2010\wd\agrmnts\rbsmgp1
22 (HCSC)	2010\wd\agrmnts\rbsclag5
26 (HCSC)	2010\wd\agrmnts\rbsshar
27 (HCSC)	2010\wd\agrmnts\rbshspm
28 (HCSC)	2010\wd\agrmnts\rbslab3
40 (HCSC)	2010\wd\agrmnts\rbsunsf3
45 (HCSC)	2010\wd\agrmnts\rbsprag
46 (HCSC)	2010\wd\agrmnts\rnhprag3
48 (HCSC)	2010\wd\agrmnts\rbshsag5
49 (HCSC)	2010\wd\agrmnts\rbshsag3
54 (HCSC)	rbsprag6

OIC ID #	Form Number
85 (HMO)	2010\wd\agrmnts\oicrcclag1
88 (HMO)	2010\wd\agrmnts\rcpragr1
98 (HMO)	2010\wd\agrmnts\rcprag3

WAC 284-43-322(4): Carriers may not require an alternative dispute resolution to the exclusion of judicial remedies.

The following provider contracts excluded judicial remedies as a method of contract dispute resolution:

OIC ID #	Form Number	OIC ID #	Form Number
1 (HCSC)	2010/wd/qgrmnts/rbsprag5	3 (HCSC)	2010/wd/qgrmnts/rbsprag3
7 (HCSC)	2010\wd\agrmnts\rbsclag3	17 (HCSC)	2010\wd\agrmnts\rbsmgp1
18 (HCSC)	Amendment combining RBS & NWMB	22 (HCSC)	2010\wd\agrmnts\rbsclag5
26 (HCSC)	2010\wd\agrmnts\rbshar	27 (HCSC)	2010\wd\agrmnts\rbshspm
28 (HCSC)	2010\wd\agrmnts\rbslab3	40 (HCSC)	2010\wd\agrmnts\rbsunsf3
45 (HCSC)	2010\wd\agrmnts\rbsprag	46 (HCSC)	2010\wd\agrmnts\rnhprag3
48 (HCSC)	2010\wd\agrmnts\rbshsag5	49 (HCSC)	2010\wd\agrmnts\rbshsag3
51 (HCSC)	TRG Participating Pharmacy Agreement	52 (HCSC)	The Regence Group Participating Independent Pharmacy Agreement
54 (HCSC)	rbsprag6	71 (HCSC)	Regendwa
74 (HCSC)	RBS Participating Dental Provider Agreement (No #)	81 (HCSC)	King County Medical Blue Shield Contract w/ Green Spring Health Services (No #)
83 (HCSC)	Diversified Pharmaceutical Services Inc. Pharmaceutical Services Agreement (No #)	85 (HMO)	2010\wd\agrmnts\oicrcclag1
87 (HMO)	HMO Washington Participating Managed Group Practice Agreement (No #)	88 (HMO)	2010\wd\agrmnts\rcpragr1
89 (HMO)	2010\wd\agrmnts\rcmgp	98 (HMO)	2010\wd\agrmnts\rcprag3
103 (HMO)	w/1010/agrmnts/rxagr99	104 (HMO)	1010\wd\agrmnts\parrx1b

Regence BlueShield

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September 14, 2004

James T. Odiorne, CPA, JD
Deputy Insurance Commissioner
Company Supervision Division
Post Office Box 40255
Olympia, Washington 98504-0255

RE: Market Conduct Examination of Regence BlueShield, RegenceCare and Asuris Northwest Health

Dear Deputy Commissioner Odiorne:

Thank you for the opportunity to respond to the draft market conduct examination report prepared for Regence BlueShield, RegenceCare and Asuris Northwest Health we received from your office.

We offer the following comments regarding the Instructions:

1. **Based on benefit summaries reviewed by the examiners that illustrated discriminatory payment levels for groups under five members, the Companies are instructed to audit and reprocess all maternity claims since 7/1/00 for The Association Plan members to assure that benefits were paid at 100% in network and 70% out of network.**

   The OIC brought this matter to our attention in late 2001 and after several months of discussion we reached an agreement with the OIC to voluntarily begin processing maternity claims at 100% in network and 70% out of network effective upon The Association Plan's renewal date of March 1, 2003. We have processed maternity claims in accordance with the agreement since March 1, 2003. This change was reflected in the groups' benefit summaries. Although we voluntarily agreed to make this change, we do not believe the different payment levels for groups under five members are discriminatory under Washington State law. In a related matter, RBS has petitioned Thurston County Superior Court to hear arguments from the OIC and RBS on the discrimination issue.

2. **Based on benefit summaries reviewed by the examiners that erroneously denied mandated coverage for neurodevelopmental therapies, the Companies are instructed to audit and reprocess all denied neurodevelopmental claims since 7/1/00 for those members covered under its HMO benefit plans.**

   The Association Plan has covered neurodevelopmental therapies since March 2000, and such coverage has been in the groups' benefit summaries. We have not offered an HMO product through The Association Plan.

3. **The companies are instructed to maintain a complete file of all advertising materials.**

Advertising materials are produced and cataloged by various departments within the company and each department is responsible for filing their respective materials. The Sales Department implemented a new centralized document retention policy that describes the process for filing (electronic and paper), cataloging advertising material and indicates how long documents should be retained. The Marketing Department retains a hard-copy version of all non-Internet materials in an Advertising File that includes a schedule of placement date(s) and duration of advertisements. All Internet content is stored in the Interwoven content management system. Historical files are available in electronic form.

4. **Based on procedures described in the Companies' underwriting manual, the Companies are instructed to review and reprocess any claims incurred that may have been inappropriately denied for adoptive children and for newborns covered by the Erin Act.**

The underwriting manual was revised on August 1, 2003 to state that newborn children are covered for 21 days from the date of birth under the current contract if the female subscriber or subscriber's female spouse is eligible for maternity benefits under the contract. None of the preexisting limitations or preexisting condition waiting apply to the subscriber's adoptive child under age 18, or child placed for adoption under age 18, if enrolled for coverage within 60 days of adoption or placement for adoption. We will review any claims incurred that may have been inappropriately denied.

5. **The Companies are instructed to revise all contract documents to clearly state that female enrollees are provided direct access to women's health services.**

We have reviewed the seventeen negotiated groups the OIC identified as not having this requirement within their plan documents, and respectfully disagree with this instruction. We worked closely with the OIC when we filed the contracts in question for approval, and the contracts were subsequently approved.

Under the standard Selections and RegenceCare products, the primary, or personal care provider coordinates the provisions of covered services to the member. Accordingly, the benefit provisions in the contract documents for these products clearly state that female enrollees have direct access to women's health services. Under the standard Traditional and Preferred Plan products, all members have direct access to providers without the need to coordinate the provision of covered services through a selected primary or personal care provider. Thus, a statement permitting female enrollees direct access to women's health services could create confusion for other members since all members have direct access to any provider for covered services. However, the benefit provisions of these contracts do clarify that Professional Benefits include covered women's health services.

6. **The Companies are instructed to revise all contract documents to include the prudent person language as defined by statute.**

All standard group and individual plan contracts were revised to include the prudent person language within the emergency definition and were filed with a July 1, 2004 effective date.

7. **The Companies are instructed to revise all contract documents to include the correct definition of allowable expense for Coordination of Benefits.**

   All standard group and individual contracts were revised to reflect the correct definition of "allowable expense" in the Coordination of Benefits section effective January 1, 2003.

8. **As previously instructed by the OIC's Rates and Forms Division, the Companies are instructed to amend the provider contracts to accurately reflect that, as an HCSC or HMO, the companies meet the definition of an issuer and are subject to laws applicable to insurance.**

   We complied with this instruction in the spring of 2003, with the approval of the OIC.

9. **The companies are instructed to include hold harmless language in their provider contracts.**

   We complied with this instruction in the spring of 2003, with the approval of the OIC.

10. **The Companies are instructed to file provider contract forms with the OIC prior to use.**

    Prior to the spring of 2003 we were in compliance with this instruction.

11. **The Companies are instructed to notify subscribers regarding terminated providers rather than requiring the providers to notify the patients.**

    We complied with this instruction in the spring of 2003, with the approval of the OIC. Under the approved provider contract, we are responsible for notifying members of a provider's termination and, as additional protection for our members, we also require providers to provide such notice.

12. **The Companies are instructed to remove the language in the provider contract forms that require alternative dispute resolution to the exclusion of judicial remedies.**

    Our provider contract language does not require alternative dispute resolution to the exclusion of judicial remedies. Rather, the contract requires alternative dispute resolution before a provider may seek judicial remedies. The OIC agreed with this process in spring of 2003.

We offer the following comments regarding the Recommendations:

1. **It is recommended that the Companies maintain accurate and complete accounts, records, documents, and files to facilitate future examinations.**

   The Exam noted two small group files were incomplete due to missing underwriting information. Underwriting information for small groups is not maintained in the Marketing file, but stored electronically in the EPI rating system. This information is available for review, and we will incorporate a process to make sure it is readily available for future examinations.

2. **It is recommended that the Companies avoid the use of false, deceptive or misleading information in its advertising.**

   While we agree with the standard pertaining to this recommendation, we do not agree with the referenced Exam finding that material related to The Association Plan was false, deceptive or misleading.

3. **It is recommended that the Companies use no advertising that omits information with the effect of misleading or deceiving purchases or prospective purchases as to the nature or extent of any policy benefit payable, or misrepresentation of the benefits or advantages of the contract.**

   While we agree with the standard pertaining to this recommendation, we do not agree with the referenced Exam finding that material related to The Association Plan had the effect of misleading or deceiving purchasers.

4. **It is recommended that the Companies assure that health maintenance agreements issued to enrolled participants fully inform participates of the health care services to which they are entitled.**

   While we agree with the standard pertaining to this recommendation, we do not agree with the referenced Exam finding since we have not offered an HMO product through The Association Plan.

5. **It is recommended that the Companies amend contracts to clearly reflect any exceptions to benefits that may be excluded from Coordination of Benefits provisions.**

   All standard group and individual contracts were revised to clearly reflect any exceptions to benefits that may be excluded from Coordination of Benefits provisions, effective July 1, 2004.

6. **It is recommended that the Companies pay 95% of clean claims within 30 day, pay or deny 95% of all claims within 60 days, and pay interest on any undenied claims more than 61 days old.**

   We currently exceed these requirements, and are correcting the one process noted in the Exam findings that could potentially cause a claim to be paid or denied outside the required timeframes.

7. **It is recommended that the Companies correctly apply the time covered by a previous health plan to the preexisting condition exclusions, limitations, or waiting periods.**

   We reviewed the case noted in the Exam findings and found the applicant and his wife should have been credited for nine months of creditable coverage for their waiting period. However, no claims were denied due to the incorrect application of the waiting periods.

8. **It is recommended that the Companies not require completion of the standard health questionnaire if the stated criteria are met.**

   While we agree with the standard pertaining to this recommendation, we do not agree with the Exam findings. We reviewed the noted case and found the selected applicant's child was born before the applicant's coverage became effective. Thus, the applicant was not a subscriber at the time the child was born, and a health questionnaire was required to add the child under the subscriber's policy.

9. **It is recommended that the Companies revise all contract documents to include the waiver of preauthorization for mental health treatment if a member is involuntarily committed to a state hospital.**

   The document cited in the Exam findings is no longer in use, and our current standard contract and brochure documents do not require preauthorization for mental health.

10. **It is recommended that the Companies include the required disclosure statement with all plans that include pharmacy services coverage.**

    We will audit our distribution methods to ensure the required disclosure statements are sent to all groups and members that include pharmacy services coverage.

11. **It is recommended that the Companies amend the provider manual(s) to correctly state the time requirements regarding appeal notification.**

    We are currently amending the internal provider appeal process and will revise our provider manual(s) accordingly.

Thank you for the opportunity to review and respond to your findings. We appreciated the professionalism and courtesy of the examiners when they were on-site last year. Please feel free to contact me if you have questions.

Sincerely,

Nancy Ellison

Nancy Ellison, JD, DrPH
Director
Public Policy & Government Programs

Cc: Michael G. Watson, Chief Deputy Insurance Commissioner
Leslie Krier, Chief Market Conduct Examiner